To: United States Department of Health and Human Services

From: West Virginia Offices of the Insurance Commissioner

Date: 10/04/10

Subject: DHHS Request for Comments Regarding Exchange Related Provision of Patient Protection and Affordable Care Act

WV Health Benefit Exchange Questions for Comment Response

A. State Exchange Planning and Establishment Grants

1. What factors are States likely to consider in determining whether they will elect to offer an Exchange by January 1, 2014? To what extent are States currently planning to develop their own Exchanges by 2014 (e.g., become electing States) versus choosing to opt-in to an Exchange operated by the Federal government for their State? When will this decision be made? Can planning grants assist in identifying and assessing relevant factors and making this decision?

- The major factors that will drive West Virginia's consideration of whether or not to establish an exchange will be the state's ability to establish the exchange in a cost efficient and fiscally sustainable manner that does not impose undue premium burdens on consumers; consideration by policymakers to preserve state autonomy and regulatory authority; and consideration of the state's ability, compared to that of the federal government, to develop an exchange that will best serve the unique needs of West Virginia's demographic and market.
- West Virginia plans to use the exchange planning grant to collect baseline information on a number of exchange issues. This information will educate policymakers on the pros and cons of various exchange policy decisions.
- While timely guidance on many exchange related issues is crucial to exchange planning and development, West Virginia strongly suggests that HHS refrain from making decisions without appropriate state input. The Planning Exchange Grants will give states an opportunity to more fully study the exchange issue and any prescriptive rules developed before this process is complete may impede states in their attempts to make the exchange the most effective tool possible for their respective citizens. While guidance on critical exchange components, including federal IT plans and potential IT infrastructure assistance, is crucial, it is strongly encouraged that HHS allow for states to perform the necessary research and stakeholder engagement so that states will be better prepared to assist HHS in development of rules and regulations.

2. To what extent have States already begun to plan for establishment of Exchanges? What kinds of activities are currently underway (e.g., legislative, regulatory, etc.)? What internal and/or external entities are involved, or will likely be involved in this planning process?

- Governor Joe Manchin III designated the West Virginia Offices of the Insurance Commissioner as the lead agency on exchange planning and development. The OIC is determined to make the exchange planning process as transparent as possible and have continued to encourage various interested parties throughout the state to participate in the process. Starting in February, with the assistance from the State Health Access Program grant from HRSA, West Virginia has performed quite extensive research into the exchange concept. Beyond looking at the histiography of the exchange, the OIC has engaged a number of other states, constituent state agencies, various WV stakeholder groups, and experts from the private sector on a host of different exchange components and concepts.
- Given the large number of questions being asked by stakeholder groups, WV strongly encourages HHS to improve and streamline the mechanism by which states ask and receive clarification on reform/ exchange related issues. An organized inventory of questions being asked by other jurisdictions would expedite our own ability to address stakeholder questions. It is crucial that questions raised be addressed thoroughly to ensure the transparency of the process and trust of the public.

a. What kinds of governance structures, rules or processes have States established or are they likely to establish related to operating Exchanges (e.g., legal structure (such as placement in State agency or nonprofit organization), governance structure, requirements relating to governing board composition, etc.)?

- WV is considering a number of governance structures based on the ACA criteria but the OIC will likely not make a recommendation for governance to policymakers until the exchange planning grant is able to provide policy scenarios and assessments on how each potential structure would function in relation to the operations of the exchange.
- WV requests guidance from the federal government regarding how stakeholders in states electing to allow the federal government to operate the exchange will be engaged. What might the governance look like for federally operated exchanges?

b. To what extent have States begun developing business plans or budgets relating to Exchange implementation?

- WV's Planning Exchange Grant specifically lists development of a business plan as a core objective. Until consumer and market surveys, actuarial assessments, and economic models can be developed based on the different policy options then development of a business plan will be premature.
- WV requests guidance from the federal government regarding how business plans and exchange budgets will be developed in states where the federal government is charged with operating the exchange. What data elements does the federal government feel are necessary to make these types of decisions?

3. What are some of the major factors that States are likely to consider in determining how to structure their Exchanges (e.g., separate or combined individual Exchanges and SHOP Exchanges; regional or interstate Exchanges; subsidiary Exchanges, State agency versus nonprofit entity)? What are the pros and cons of these various options?

- Until stakeholders can be thoroughly engaged and consumer and market surveys, actuarial assessments, and economic models can be developed, then it is impossible for the state to outline all of the potential pros and cons of the various factors being considered. The following represents *some* of the identified areas that require policy consideration:
    i. Data elements and policy issues that should be sought in exchange planning
    ii. Implementation Timeframes and Considerations
    iii. Governance
    iv. Roles of state agencies
    v. Ancillary exchange functions
    vi. Consumer information
    vii. Role of agent, navigators
    viii. Negotiate plan premiums
    ix. Network adequacy
    x. Quality measures
    xi. Marketing
    xii. Eligibility and Enrollment
    xiii. Nationwide Plans
    xiv. Inside/outside regs
    xv. Multi-State exchange
    xvi. Mandated benefits
    xvii. Funding of operations
    xviii. Combine ind. small groups
    xix. Large groups
    xx. Negotiate provider prices
    xxi. Competition
    xxii. Consumer Disclosure
    xxiii. Multi-state offering of plans
    xxiv. Collection and Remittance
    xxv. Medicaid/CHIP Issues
    xxvi. Outreach
    xxvii. Rating Areas
    xxviii. Employer Participation
    xxix. Consumer Experience
    xxx. Risk Adjustment, Reinsurance, and Risk Corridors
    xxxi. All payer claims database usage
    xxxii. Master Client Index
    xxxiii. Consumer Privacy Protection

- WV requests guidance from the federal government regarding factors being considered by the federal government in the development of an exchange for states electing to not develop their own.

4. What kinds of factors are likely to affect States' resource needs related to establishing Exchanges?
- Factors driving costs in the planning and development stage of the exchange are development of consumer and industry surveys, actuarial assessments, economic modeling, policy assessments, an education and outreach strategy, a technological infrastructure strategy, a business plan, a facilitation contract, exchange planning staff salary and fringe, stakeholder engagement, technological infrastructure, potential third party administrator services, web development, development of a 24/7 telephone hotline, development of navigator and agent interfaces and payment structures, and outreach and education. This list is not comprehensive and additional funding needs will be determined as the state moves forward with planning and development.

b. To what extent do States have existing resources that could be leveraged as a starting point for Exchange operations (e.g., existing information technology (IT) systems, toll-free hotlines, Web sites, business processes, etc.)?
- The following represents a sample of existing state resources where synergies may be found:

1. A state eligibility system for subsidized health care and social services, InROADS. The potential for using this platform for the exchange is being studied.
2. The Consumer Services division of the OIC has a telephone hotline, which serves as the front line for current questions/concerns regarding insurance. This division has the expertise that could be leveraged to train/staff the exchange hotline. It is likely, however, that additional resources will be needed in this area.
3. Rates and Forms experts in the OIC could potentially be used to help determine the actuarial tiers of plans and determine what plans meet the certified qualified plan criteria.
4. IT staff in the OIC and in state government may be able to develop and maintain certain components of the health insurance exchange technology infrastructure.
5. Quality reporting tools could be developed based on current platforms being developed and refined by the WV Health Care Authority.
6. Consumer case management for those transitioning between the exchange and CHIP/Medicaid could be assisted by a number of existing groups and organizations in the state, including the Bureau for Children and Families; the Family Resource Network; and several consumer advocacy groups.

- WV request guidance from the federal government regarding what existing infrastructure resources will be made available to the states.
- There will be many technological similarities across different exchanges, including eligibility portals, premium aggregators, carrier menus, and enrollment portals. As the federal government develops technological infrastructure components for the federally operated exchange, there is great potential for that technology to be used by the states through open source code sharing or through some contractual

licensure agreement. WV requests guidance on when these infrastructure components might be developed and if and when they would be made available to the states and what the federal government's plans are, generally, concerning sharing infrastructure pieces with states.

c. For what kinds of activities are States likely to seek funding using the Exchange establishment and planning grants?

- The following are areas where WV requested funding as part of our planning exchange grant:
    - Consumer Surveys
    - Industry Surveys
    - Actuarial Assessments and Economic Models
    - Policy Modeling
    - Development of a Business Plan
    - Development of an Education and Outreach Plan
    - Development of a Technological Infrastructure Plan
    - Development of a facilitation contract
- Allotment for state travel for stakeholder engagement and national travel for research and development
- West Virginia requests guidance on when (approximate date) additional federal grants may be available and for what amount.

5. What kinds of questions are States likely to receive during the initial planning and start-up phase of establishing Exchanges? How can HHS provide technical assistance, and in what forms, in helping States to answer these questions?

- Thus far the state has received a number of questions/comments and through the OIC's current stakeholder engagement activities more comments will be gathered. Additional input from the public will continue through stakeholder engagement efforts. It is strongly suggested that HHS refrain from developing any prescriptive rules/regulations until states have an opportunity to properly engage the public and study the various exchange issues being considered.
- Per previous comment, WV strongly encourages HHS to improve and streamline the mechanism by which states ask and receive clarification on reform/ exchange related issues. An organized inventory of questions being asked by other jurisdictions would expedite our own ability to address stakeholder questions. Also, an approximate timeline for the release of federal regulations relating to the exchange would at least give the states the ability to give the public a sense of when certain questions will be answered.
- Furthermore, WV requests clarification on the process HHS anticipates using to engage stakeholder groups and the public in states that elect to defer to the federal government in operation of the state exchange.

B. Implementation Timeframes and Considerations

1. What are the key implementation tasks that need to be accomplished to meet Exchange formation deadlines and what is the timing for such tasks? What kinds of business functions will need to be operational before January 1, 2014, and how soon will they need to be operational?

- West Virginia is working with the NAIC in the development of model legislation. The governance of the exchange must be determined and specific exchange functions must be outlined. In 2011, the Planning Exchange Grant will assist the state in further developing a strategy and timeline for implementation. It is anticipated that if WV chooses to develop its own exchange, technology procurements will be made in late 2011 or early 2012. Testing of the exchange needs to begin in 2012 and covered lives should be run through the exchange no later than early 2013 to ensure complications are worked through.
- West Virginia requests insight into when states electing to have the federal government operate their state exchange will see that exchange tested and operational.

2. What kinds of guidance or information would be helpful to States, plans, employers, consumers, and other groups or sectors as they begin the planning process?

- West Virginia needs guidance on what technology components the federal government will be able to make available to the states and under what type of contractual and financial agreement this will take place. Guidance for a number of other exchange related components is also necessary. WV will be unable to fully outline what recommendations it would have to HHS in the development of rules until the planning exchange grant studies and models are given time to produce data. West Virginia will be working with the NAIC to develop white papers and operational options as this information becomes available.
- West Virginia strongly suggests that HHS refrain from making decisions without appropriate state input. The Planning Exchange Grants will give states an opportunity to more fully study the exchange issue and any prescriptive rules developed before that time may impede states in their attempts to make the exchange the most effective tool possible for their respective citizens. West Virginia would, however, request as much insight into the projected timelines for rules, guidance, and federal exchange development as possible.

3. What potential criteria could be considered in determining whether an electing State is making sufficient progress in establishing an Exchange and implementing the insurance market reforms in Subtitles A and C of Title I of the Affordable Care Act? What are important milestones for States to show they are making steady and sufficient progress to implement reforms by the statutory deadlines?

- The adoption of authorizing legislation by no later than 2012 is one potential factor that could lead to federal development of an exchange. Planning needs to already be underway in states and the Planning Exchange grant should give states the information to determine whether or not a state should defer to the federal government in development and operation of the exchange. Testing of the exchange should begin by 2012 and no later than early 2013.
- West Virginia requests that HHS clarify what milestones that are being considered from states in order to give the federal government time to implement the exchange. West Virginia also would like insight into what development timelines HHS has given itself in order to construct exchanges in states.

4. What other terms or provisions require additional clarification to facilitate implementation and compliance? What specific clarifications would be helpful?

- As more research takes place into the development and construction of exchanges it is likely that more specific clarification will be needed. Specifically, guidance is requested as it relates to steps being taken to prevent adverse selection via the risk adjustment tool, risk corridor and reinsurance provisions. Guidance is requested as it relates to the role of the insurance agent and navigator. Guidance is requested as to the provision outlining that states must pay for state mandated benefits- what if a state does not allocate this funding? Clarification is requested on the development of regional exchanges. Clarification is requested on eligibility determination as it relates to MAGI and further clarification on what options are available to states in determining appropriate Medicaid match for current and new covered populations. Clarification is requested on how states will specifically interface with the various federal systems, such as the IRS for penalties, Homeland Security for citizenship, and Department of the Treasury for payment of subsidies. Clarification is requested on whether small defined contributions from employers can be aggregated with federal subsidies. Clarification is needed on the rating of plans. Clarification is needed on plans available across state jurisdictions. Cost projections are requested for federally operated exchanges so as to determine what fees or premium increases might be entailed with that operation. Clarification is requested on the development of the Basic Health Plan. Clarification is requested on the quality provisions outlined as it relates to plans contracting with providers or incentivizing payments to providers for specific quality initiatives. General clarification is requested on the timeline of federal development of rules, exchange infrastructure, and future grant opportunities. Again, it must be emphasized that federal guidance should be developed so as to assist states in making exchange decisions as opposed to imposing requirements on states. Clarification of the law should also be made in a manner that is least restrictive. State flexibility will be crucial for the exchanges to be successful.

C. State Exchange Operations

1. What are some of the major considerations for States in planning for and establishing Exchanges?

- Planning for Exchanges must take into account many different factors, such as the structure and characteristics of each state's health insurance market, the number and characteristics of the uninsured in the state, the number and characteristics of individuals who are expected to be eligible for subsidies, the number and market share of carriers currently participating in the individual and small group markets, premiums and types of coverage offered in the marketplace, the penetration of health maintenance organizations (HMOs), the types of policies that predominate, and laws and regulations that currently govern the markets. Planning for Exchanges must take into account many different factors, such as the structure and characteristics of each state's health insurance markets, the number and characteristics of the uninsured in the state, the number and characteristics of individuals who are expected to be eligible for subsidies, the number and market

share of carriers currently participating in the individual and small group markets, premiums and types of coverage offered in the marketplace, the penetration of health maintenance organizations (HMOs), the types of policies that predominate, and laws and regulations that currently govern the markets.

2. For which aspects of Exchange operations or Exchange standards would uniformity be preferable? For which aspects of Exchange operations or Exchange standards is State flexibility likely to be particularly important?

- Core technology infrastructure will likely be very similar in all exchanges. This includes but may not be limited to the eligibility portal, premium aggregator, carrier menu, enrollment portal, risk adjustment tools, and payment and remittance. While each of these components may have some variation from state to state the technology driving the systems will be the same. In that, there is potential for great savings if either the federal government can provide timely and quality driven technology pieces to states or if states leverage their combined pools to negotiate prices down with potential vendors. More research needs to be conducted to further develop these concepts.
- What core technology infrastructure is HHS looking to develop for exchange systems? What may be made available to states? How might such technology infrastructure components be made available to the states?

3. What kinds of systems are States likely to need to enable important Exchange operational functions (e.g., eligibility determination, plan qualification, data reporting, payment flows, etc.), to ensure adequate accounting and tracking of spending, provide transparency to Exchange functions, and facilitate financial audits? What are the relative costs and considerations associated with building Exchange operational, financial, and/or IT systems off of existing systems, versus building new stand-alone Exchange IT systems?

- The state is not yet in a position to respond to this question and will use the Planning Exchange Grant to this end. The following represents a sample of some of the technology pieces that WV is researching:
    - Eligibility Portal: Portal could give consumer ability to input relevant personal information, which will allow electronic assessment of public plan and federal subsidy eligibility. Portal could also give consumer option to input employer or other account code, giving exchange the ability to pull from various accounts set up on consumer's behalf. Eligibility portal will connect to all available health insurance coverage opportunities in the state of West Virginia, including linking consumer to commercial insurance plans for individuals, small groups, and associations via a carrier menu. If consumer is eligible for public plan, consumer will be directly linked to eligibility/enrollment portal for specified public plan.
    - Premium Aggregator: Upon inputting specific income and employer information, consumer will have all premium contributions aggregated. As consumer compares and contrasts plans in the carrier menu, they will know the aggregated contribution to their coverage from other entities,

thus giving them a better tool by which to budget for and purchase the plan that best serves their needs.

- Coverage Decision Making Assistance Tool: As consumer navigates the exchange, they could be given option to respond to questions in a guided decision-making tree that would direct consumer to plans that best serve their health care needs. Such a tool would be voluntary and include a disclaimer that consumer should take time to fully research coverage options available to them.
- Carrier Menu: Exchange provides access to a carrier plan menu for consumers looking to purchase commercial insurance. This menu will allow consumers to compare and contrast critical insurance metrics with more detailed plan descriptions also being available. Carrier menu will be linked to any available federal subsidies and other account contributions set up for consumer. Menu will be structured in five actuarially determined tiers per federal guidelines, with one being available to only young adults.
- Standardized Enrollment Portal: Upon selection of a carrier plan, exchange will facilitate the consumer's purchase of coverage by collecting relevant information and linking to carrier or by directly linking consumer, with input selected plan and eligibility information, into carrier enrollment system.
- Premium Collection and Remittance: The Exchange could perform accounting functions to remit premiums and prepaid amounts to the various insurers and brokers or participating health care organizations, including payroll deduction for premium or prepayment for coverage. Through economy of scale, the exchange could potentially perform these functions more efficiently.
- Employer Exchange Kits/Software: Small and eventually large employers can utilize the functions of the exchange to streamline the administrative burden that providing coverage to their employees results. To effectively utilize the exchange, an employer kit could be developed that systematically outlines all of the steps that an employer needs to take to use the exchange.
- Portability of Coverage: It is contemplated that Exchange will facilitate portability of coverage as employee transitions from employer to employer. This concept faces obstacle of different employers choosing different tiers of coverage for their employees.
- Link to Regional Exchange: WV has considered two potential benefits of regional exchanges. The first option would be to provide coverage to consumers from multiple states/regions in a single exchange or give a consumer access to multiple exchanges. This would benefit consumers by either increasing the number of participants in plans from which they choose. It could also provide them with regionally attractive options, especially for consumers living in border counties. State mandatorily covered services and variations in state regulations make this concept difficult to realize. The second option would be to share administrative

functions with other state exchanges. For example, having one vendor that would be able to collect and remit premiums in more than one exchange could potentially see savings through an economy of scale.

- Insurance Consultant/ Counselor Assistance: A web portal is only one means by which consumers will access exchange. Given computer/ internet access and literacy issues, insurance counselors have been designated in the SHAP budget for consumers to access via phone or web chat. The Call Center/Live Chat for health insurance questions and assistance, is conceptually modeled after and incorporating elements of the State Health Insurance Assistance Program for Medicare.
- Multiple Exchange Access Points: WV Consumers need multiple access points into the exchange so that they are assured to receive appropriate subsidies and other services as provided by the exchange. Given literacy levels, lack of computer access, and poor broadband linkages, it is absolutely essential that the exchange is not just a web portal. Beyond the required call center, plans are being developed to utilize a number of organizations already established in communities, including Family Resource Networks; DHHR case workers; volunteers; and other community groups to serve as insurance exchange facilitators and counselors.
- All Payer Claims Database: Through an executive order by the Governor, DHHR is leading a task force to establish an APCD. This tool could function to provide consumers with both provider charges within a carrier network and quality assessments of those providers in carrier networks. Other quality comparison tools still need to be considered and worked out with various state entities and other interested parties.
- Master Client Index: In that state client service and consumer health coverage systems do not communicate with one another, the state is unable to ascertain exactly how many clients are being served at any one time because some of these services overlap. The state is also unable to track individuals across state systems, meaning that the state is unable to determine continuity of care for vulnerable populations. In that some public health programs will continue to overlay various types of coverage for the underinsured, it is in the state's best interest to coordinate these overlays and track coverage trends as much as possible for resource allocation and case management purposes.
- Health Coverage Matrix: An overview will be made available of all health coverage available in state of West Virginia. While consumer will be able to access these programs via the eligibility portal, consumer also will have option of reviewing the universe of available services in a matrix document on the exchange website.
- Agent/Broker Access: Agents and brokers are key stakeholders as the exchange is developed. Their role in the exchange needs to be further fleshed out. Consumers that want to utilize the service of an agent or broker should not be precluded from doing so. Concepts are being

considered that would give agents/brokers special access to the exchange to perform their job functions for consumers.

- Other Consumer Tools: In that the Exchange's primary function is to empower the consumer to make good decisions on purchasing coverage, we have considered several tools to give to consumers pertinent information. Such tools being considered include: carrier in-network maps; providers by zip code; cost comparisons of medical providers; carrier complaints matrix; community wellness resources; and social media review functions.
- Other Exchange Information: Functions such as FAQ, About Us, Common Terms, and a health insurance and exchange tutorial will also be available through the exchange.
- Personal Health Record: A personal health record empowers consumer to take responsibility and ownership of their health and health care. PHRs could potentially have functionality to incorporate other information as well, including health coverage and paid claims information. Could PHR serve as possible distinction between plans in tiers of exchange- some plans incorporate such a function while others do not?

4. What are the tradeoffs for States to utilize a Federal IT solution for operating their Exchanges, as compared to building their own unique systems to conform to the current State environment? For what kinds of functions would it make more sense for States to build their own systems, or modify existing systems?

- While a federal IT option may provide some efficiencies/savings for the overall exchange budget, there is concern about both the timeliness and flexibility of the federal IT solution in interfacing with state specific needs/systems. To address this, West Virginia suggests that states be given a number of IT options by the federal government but that solutions not be prescribed. Ultimately flexibility in exchange operations and the capacity for a state exchange to make the necessary adaptations to federal IT components will be crucial in a state's development of a system that best fits the relative demographics and market in that state.

5. What are the considerations for States as they develop web portals for the Exchanges?

- West Virginia is considering a number of factors in planning the exchange web portal, including the cultural, linguistic, literacy, computer and internet availability and socio economic backgrounds of consumers that are anticipated to use the exchange. It is extremely important that multiple access points and means by which to navigate the exchange be developed in West Virginia so that those not comfortable or capable with the web portal process can still access coverage. West Virginia would suggest that the federal government strongly consider making available to states funding to develop community resources and outreach programs to ensure that maximum coverage potential is realized, especially in poor and rural communities.

6. What factors should Exchanges consider in reviewing justifications for premium increases from insurers seeking certification as QHPs? How will States leverage/coordinate the work funded by the rate review grants to inform the decisions about which plans will be certified by QHPs?

- The OIC will continue to balance affordability of the insurance policy with the solvency of the carrier. It is strongly felt that the experience and expertise of the rates and forms division of the OIC in conducting rate review make that office the prime location for determining certification for Qualified Health Plans. To perform this function in another entity may risk duplication of regulatory functions and confuse solvency status and affordability. Such duplication could also create potentially costly reporting burdens for payers.
- West Virginia requests clarification on how the federal government will determine what plans meet the qualified health plan status in states where the federal government operates the exchange.

7. To what extent are Territories likely to elect to establish their own Exchanges? What specific issues apply to establishing Exchanges in the Territories?

- NA

8. What specific planning steps should the Exchanges undertake to ensure that they are accessible and available to individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

- As has been stated in other comments, it is crucial that multiple access points be developed, including telephone and in person enrollment through agents, navigators, etc. It is also crucial that system interfaces be as seamless as possible so as to mitigate the level of confusion on behalf of the consumer. Finally, it is important that the exchange operate as a market tool and be driven by consumer choices. The exchange must be flexible enough to adapt to evolving consumer needs. The exchange must also be laid out in a manner that facilitates the consumer's understanding of their health insurance options. It is important for those developing exchanges to realize that this platform is selling plans on behalf of carriers and organizing the market, streamlining the purchase of coverage, and providing crucial information to consumers. Thus, the exchange must be nimble enough to react to shifts in the consumer market in a manner that is as cost efficient as possible.

9. What factors should the Secretary consider in determining what constitutes as wasteful spending (as outlined in Section 1311 (d)(5)(B))?

- It is crucial that an exchange be cost efficient. Wasteful spending and fraud will not be tolerated in an exchange developed for West Virginia citizens. The HHS should work as closely as possible with states and avoid arbitrary determinations of what is wasteful and what is not. It is important that HHS work with states and fully study the specific dynamics of a state's decisions.

D. Qualified Health Plans (QHPs)

1. What are some of the major considerations involved in certifying QHPs under the Exchanges, and how do those considerations differ in the context of individual and

SHOP State Exchanges, subsidiary Exchanges, regional or interstate Exchanges, or an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange?

- The affordability of the policy and the solvency of the carrier remain crucial factors driving certification of QHPs, regardless of the governance structure.
- Per the NAIC, "State-based Exchanges must consider the cost of the certification process, both to the Exchange and to the companies. They must also consider how the requirements placed on Exchange plans differ from the requirements on plans in the outside market. Do the differences encourage or discourage participation in the Exchange? Do the differences create adverse selection? These considerations are multiplied for regional and interstate Exchanges. Is there sufficient uniformity among the state requirements to provide real savings to the Exchange and the plans? Do the Exchange requirements differ significantly from the outside market in any of the states and what is the impact of such differences? A federal-exchange must be particularly cognizant of the differences between federal rules and the state laws and regulations that apply to the outside market. Staying out of the Exchange may be a real option for many plans if the federal requirements are costly or onerous."

2. What factors should be considered in developing the Section 1311(c) certification criteria? To what extent do States currently have similar requirements or standards for plans in the individual and group markets?

- Federal criteria should take a minimalist approach so as to allow the greatest degree of state flexibility in finding solutions for a state's residents and market. It is felt that standards for marketing and network adequacy should remain as closely aligned as possible both in and out of the exchange to prevent adverse selection.

a. What issues need to be considered in establishing appropriate standards for ensuring a sufficient choice of providers and providing information on the availability of providers?

- Network adequacy is one important component. As referenced from the NAIC, "Network adequacy requirements are an important protection for consumers in managed care plans that provide lower coverage, or no coverage at all, for services provided by out-of-network providers. If network adequacy standards are not strong enough, consumers may be left without access to critical care when they need it. However, rules that are too tight could restrict the ability of managed care plans to negotiate lower reimbursement rates with health care providers, particularly in rural areas, while rules that are. The NAIC's Managed Care Plan Network Adequacy Model Act provides a framework that, in conjunction with other state laws should provide some guidance in developing these standards."
- Concerning providing information on providers, there may be potential to outline for consumers what providers charge in specific carrier networks so that consumers can

compare that between plans. With that would be concerns about protecting carrier contracts so clarification is needed on how the HHS envisions that information being made available and how this will function in the federally operated exchange. Also, there is a concern about providing only financial data on different providers, which may function to drive consumers to more expensive providers because of the logical, although not always appropriate, association between cost and value. It is recommended that HHS help states, but not mandate, the development of a uniform and fair mechanism by which to place provider charges and quality data on the exchange as a tool for consumers. Potential grant funding to this end may be helpful.

b. What issues need to be considered in establishing appropriate minimum standards for marketing of QHPs and enforcement of those standards? What are appropriate Federal and State roles in marketing oversight?

- West Virginia agrees with the NAIC assessment that state insurance regulators have many years of experience regulating insurers' marketing activities, as well as the conduct of agents and brokers. State insurance regulators should continue to bear the primary responsibility for setting and enforcing marketing standards. Federal exchange marketing standards should defer to state marketing rules when applicable.

3. What factors are needed to facilitate participation of a sufficient mix of QHPs in the Exchanges to meet the needs of consumers?

- States should be given maximum flexibility to design exchanges so as to ensure that the exchange is the primary marketplace and is not adversely selected against. If federal regulations are too prescriptive and fail to give states the ability to be nimble enough to react to unique characteristics in the state's market then there is potential for carriers to forgo participation in the exchange. How does the federal government plan on compelling carriers into the exchange? Will the federal government attempt to leverage in as many plans into the exchange as possible or will plan participation be limited in the federal exchange plans?
- There is particular concern about the viability of the SHOP exchange. How will the federal exchange convince employers to enter the SHOP exchange as opposed to remaining out of the exchange and purchasing through a producer? How will employers that currently use producers benefit from the SHOP exchange? Is there potential for crowd out as tax credits sunset in 2016? West Virginia is developing strategies to make the exchange as attractive to the business community as feasible and it is recommended that the federal government make a better effort at reaching out to the business community on exchange adoption.

a. What timeframes and key milestones will be most important in assessing plans' participation in Exchanges?

- Exchange operations and rules must be clearly outlined with appropriate carrier input from the beginning of the planning process in order to ensure carrier plan participation in the exchange. Rules should be developed in a manner that give carriers the opportunity to provide input and prepare for adoption well before exchange testing begins. How will the federally operated exchanges reach out to

stakeholder groups, like state carriers, in a timely enough manner to ensure plan access and availability?

4. What health plan standards and bidding processes would help to facilitate getting the best value for consumers and taxpayers?

- West Virginia continues to research this issue and will continue to do so as part of the Planning Exchange Grant. What does HHS anticipate to be the process for bidding processes to facilitate getting the best value for consumers and taxpayers in federally developed exchanges?

5. What factors are important in establishing minimum requirements for the actuarial value/level of coverage?

- Knowing the essential benefit levels and having more insight into how state mandate benefits will be covered are two critical components of this equation. It is crucial that states be actively engaged in development of rules on essential benefits. Beyond that, more guidance is needed on how the actuarial tiers are being developed. Will there be a range within each tier or will actuarial assessments attempt to be exact? Is that even feasible? What process is recommended for developing, reviewing and approving the criteria for the actuarial levels of plans? How does the federal government anticipate approaching this issue as part of the federal exchange?

6. What factors, bidding requirements, and review/selection practices are likely to facilitate the participation of multiple plans in Exchanges? To what extent should the Exchanges accept all plans that meet minimum standards or select and negotiate with plans?

- West Virginia is working with the NAIC in developing a white paper to outline options for states on whether plans participation will be limited in the exchange.

7. What are some important considerations related to establishing the program to offer loans or grants to foster the promotion of qualified nonprofit health plans under CO-OP plans? How prevalent are these organizations today? What is the likely demand for these loans and grants? What kinds of guidance are they likely to need from HHS and what legislative or regulatory changes are they likely to need from States?

- West Virginia is currently exploring different payer models. States will need to develop legal/ regulatory mechanism by which to license and regulate CO-OPs.
- West Virginia requests further guidance on how COOPs are intended to function. What is the process for such proposals to be evaluated and funded?
- West Virginia requests guidance as to the legality and regulatory parameters of provider based coverage plans and provider centered risk models in the exchange.

8. Are there any special factors that are important for consideration in establishing standards for the participation of multi-State plans in Exchanges?

- West Virginia reiterates the same message being advocated by the NAIC that multi state plans must be licensed in each state in which it operates and comply with all state required consumer and solvency protections.

9. To what extent are States considering setting up State Basic Health Plans under Section 1331 of the Act?

- West Virginia is considering the implications of a state basic health plan. Further federal guidance and funding for research of the concept and its impact on the exchange and Medicaid populations would be helpful.

E. Quality

1. What factors are most important for consideration in establishing standards for a plan rating system?

- States need to be given time to research the proposed rating system before appropriate input can be provided. Given unique dynamics of different state markets and demographics, it will be essential that states be given maximum flexibility in plan rating systems.
- What is the anticipated formula in developing a rating system in federally operated exchanges?

2. What are some minimum standards or other factors that could be considered with respect to establishing quality measurement and improvement thresholds or quality requirements that should be met by QHPs? What other strategies, including payment structures, could be used by plans to improve the practices of plan providers?

- Consideration should be given to the sometimes limited capacity that carriers have in negotiating rates with large providers. In some cases, these negotiations strongly favor the provider so much so that the payer has little leverage in negotiating down rates or driving quality initiatives. HHS must simultaneously engage the provider and payer communities in determining how to best structure quality recommendations to states. These recommendations should be developed with evidence based practices that have solid consensus from the payer and medical professional communities. It is crucial that HHS work to bring providers and payers to the same table as these discussions are held.

F. An Exchange for Non-Electing States

1. How can the Federal government best work to implement an Exchange in States that do not elect to establish or are unable to establish their own Exchanges?

- If West Virginia elects not to operate an exchange the federal government must have the capacity and dedication to engage all the appropriate state level stakeholder groups in the same process that the state currently plans on taking. This process cannot be rushed. The federal government must also find a way to engage state stakeholders on core policy questions- to adopt a specific policy based on a theoretical model or to develop uniform exchanges based on the dynamics of a specific state and apply it to the rest of the states will result in poor execution and would be unacceptable for the citizens of West Virginia. Insurance regulators at the state level must be especially involved in any efforts to develop an insurance exchange given the regulatory functions, state specific expertise of insurance regulators, and the need to parallel exchange regulation with that of the outside market.

- The ACA states that states must have plans to HHS on exchange development by no later than January 1, 2013. What will be required as part of these plans and will this date be pushed sooner to give the federal government more time to lay down appropriate ground work in states not choosing to develop an exchange?

2. Are there considerations for an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange that would be different from the State-run Exchanges?

- It is felt that it will be very difficult for the federal government to develop the state specific expertise and stakeholder relationships in the allowable timeframe so as to be able to functionally and successfully develop state specific health insurance exchanges.
- Per the NAIC, "Federally-operated Exchanges will face a number of unique challenges during the implementation process. Besides those shared challenges that State-operated Exchanges also face, the federal government will need to cognizant of the difficulty of operating in diverse market environments with different regulations that reflect those differences and the difficulty of interacting with multiple state Medicaid eligibility systems. Federally-operated Exchanges should deal with the diversity of market environments by working as closely as possible with insurance regulators in the state and by deferring, to the maximum extent possible, to the regulatory standards and decisions of these regulators…There may be multiple ways for Federally-operated Exchanges to deal with multiple State Medicaid eligibility systems. These may include development of an information system that can be easily adapted to work with various systems or contracting with Medicaid programs to have them conduct these determinations on behalf of the Exchange."

G. Enrollment and Eligibility

1. What are the advantages and issues associated with various options for setting the duration of the open enrollment period for Exchanges for the first year and subsequent years? What factors are important for developing criteria for special enrollment periods?

- Year around open enrollment would create great instability in the exchange market. If consumers select and pay into a bronze plan but then when services are necessary select a platinum plan and then once services rendered they drop back to the bronze plan, the market will be wrecked. States need to be given the flexibility to structure open enrollment periods so as to protect the stability of the market, give consumers time to shop and select coverage, and give states the ability to appropriately regulate/administer eligibility and enrollment activity. Per the NAIC, "Special enrollment periods should be available when dependents become eligible, or cease to be eligible, for coverage on a family policy, such as by birth, death, marriage, or divorce; when an individual loses coverage with their current carrier, such as termination of employment, when an insurer to ceases offering coverage, or through a change of residence outside the current insurer's service area."

2. What are some of the key considerations associated with conducting online enrollment?

- Online enrollment needs to be seamless for the consumer in terms of how the enrollment function coincides with other exchange functions. Online enrollment should be made as simple as possible with alternative enrollment avenues via telephone, producer, navigator, etc available for consumers not comfortable or capable of navigating the digital process. Administrative burden should be kept to a minimum.
- Does HHS envision enrolling consumers directly into plans or merely linking the consumer with the carrier offering the plan that the consumer has chosen and allowing that carrier to facilitate enrollment?

3. How can eligibility and enrollment be effectively coordinated between Medicaid, CHIP, and Exchanges? How could eligibility systems be designed or adapted to accomplish this? What steps can be taken to ease consumer navigation between the programs and ease administrative burden? What are the key considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility for all three programs?

- Per the NGA, "We ask that the definition and parameters for the new MAGI criteria be identified as soon as possible to ensure Medicaid systems as well as exchange systems are built to accommodate and meet this definition." WV needs guidance on this matter as soon as possible so that appropriate planning can take place. This is an extremely complicated endeavor. Ultimately, the state needs to explore all the options to determine what the most efficient and effective health eligibility system(s) plan is for West Virginia. If CMS, the ONC, and OCIIO develop a streamlined eligibility form and from that an open source eligibility portal with all the appropriate interfaces built in and make it available to the state in a timely manner then it could have great potential in cost savings for the state. Regardless of how the eligibility functions are developed, they must be seamless with other exchange system components.
- More guidance is needed concerning the process by which Medicaid match will be determined for currently covered consumers and consumers that will be covered as part of the expansion in 2014 so as to determine the appropriate state match. Any mechanism that allows the state to streamline eligibility for all consumers without the risk of an audited driven clawback at some future date would be ideal.
- It is strongly recommended that the federal systems developed to determine subsidies for consumers, verify citizenship, assess penalties for failure to comply with federal mandate, etc be developed in a manner that requires states to make a minimal number of connections with federal systems. If such systems could somehow be intertwined, providing one interface, it would potentially save the states a great deal of resources.

- Per the NGA, "Beyond eligibility, there are related efforts that may also need to be accommodated in the operations and systems being developed. These efforts include Health IT, horizontal human services eligibility project at ONC, plan rating for quality and cost, TPL efforts and MMIS and eligibility system merging and redesign. We ask that states be consulted on these issues to ensure operational structures and technical systems can accommodate any related requirements. We also ask that HHS be clear on how they intend to integrate these into exchange systems. The data sources for eligibility under ACA are federally-based (DHS, IRS). There needs to be smooth lines of communication, auditing, and updating between state exchanges and federal data sources, and states cannot be unfairly penalized for discrepancies."

H. Outreach

1. What kinds of consumer enrollment, outreach, and educational activities are States and other entities likely to conduct relating to Exchanges, insurance market reforms, premium tax credits and cost-sharing reductions, available plan choices, etc., and what Federal resources or technical assistance are likely to be beneficial?

- The WV OIC has developed a multi tiered strategy to engage West Virginia stakeholders. As the designated entity appointed by the Governor to research and plan for the development of the health insurance exchange, the OIC has made a concerted effort to engage constituent state agencies on a number of exchange related issues. As part of the public stakeholder engagement efforts, the OIC will have stakeholder meetings around the state through the month of October and November. Running parallel to this effort, a WV specific request for comment period will be announced in the state register. Following these public stakeholder meetings, community of interest groups will be developed to address specific exchange policy areas. Throughout this entire process, the OIC will reach out to a plethora of organizations and groups in the state for one on one dialogue and input. To fund these efforts, WV's planning exchange grant and State Health Access Program grant will be utilized. In order to sustain such efforts, federal grant funding for future exchange efforts will be paramount.
- How will the federal government engage stakeholders in states that defer to the federal government to develop an exchange?
- Will federal grant funding be made available to assist states with education and outreach efforts on the health insurance exchange?
- It is recommended that the federal government develop an outreach and education strategy in consultation with the states for the coverage expansions and subsidy availability in 2014.

2. What resources are needed for Navigator programs? To what extent do States currently have programs in place that can be adapted to serve as patient Navigators?

- It is unknown at this time what resources may be necessary for Navigator programs. Crucial questions are still outstanding in relation to the navigator. It may be

necessary for navigators to be formally trained and certified in a manner parallel or equivalent to that of producers.

- The OIC is currently working with West Virginia's producer community as well as other community outreach assistance programs to better understand the scope and role of navigators moving forward.
- How will the federal government certify navigators in federally operated exchanges? How will the federal government compensate navigators and producers in federally operated exchanges?

3. What kinds of outreach strategies are likely to be most successful in enrolling individuals who are eligible for tax credits and cost-sharing reductions to purchase coverage through an Exchange, and retaining these individuals? How can these outreach efforts be coordinated with efforts for other public programs?

- The OIC will work with a number of stakeholder groups in West Virginia in order to develop appropriate and effective education and outreach materials for citizens eligible for tax credits and cost sharing reductions. What resources can the federal government make available to states in developing successful outreach strategies? It is recommended that the federal government develop a public education campaign for the 2014 coverage initiatives and launch said campaign in consultation with states well in advance of January 1, 2014. The better such strategies are coordinated with states the more effective messaging and branding can be accomplished.

I. Rating Areas

- It is strongly recommended that states be given maximum flexibility in determining and developing geographic rating areas within the state. Concerning regional exchanges, it is strongly recommended that states be given maximum flexibility in working with other states to best determine how such regional rating differences should be structured.
- When will criteria be developed by HHS to determine the validity of rating areas developed by states? When will HHS address the development of state rating areas through guidance or rule? What methodology will be used by HHS in developing rating areas in states that fail to do so, or that fail to do so to HHS standards?

J. Consumer Experience

1. What kinds of design features can help consumers obtain coverage through the Exchange? What information are consumers likely to find useful from Exchanges in making plan selections? Which kinds of enrollment venues are likely to be most helpful in facilitating individual enrollment in Exchanges and QHPs?

- Generically, the exchange should be developed in a manner that is consumer oriented and tested. An exchange should function seamlessly, regardless of external interfaces that must be made to validate information at either the state or federal level. An exchange should also work as seamlessly as possible when linking consumers to carriers to actually enroll in coverage or when linking consumers to publically subsidized health coverage options.

- If a consumer's financial situation changes from the point where eligibility is determined to the end of the year will the federal government require that consumer to reimburse the federal government for what has been allocated to that consumer per the federal subsidy?
- What will the timeframe be for income data used to determine eligibility?
- Will states or the exchange be held liable if a consumer's eligibility is determined to be incorrect for the purpose of the federal tax credit?
- How will the premium tax credit be paid to carriers? Will the federal government directly reimburse carriers based on the selected plan? Will the exchange serve as a conduit for the premium tax credit payment from the federal government to the carrier? This latter option may have merit in that through the flow of the exchange eligibility for the premium tax credit will take place prior to plan selection.
- Per both the NGA and NAIC, West Virginia strongly requests guidance with regard to how an exchange will interface with federal agencies. It is also strongly requested that the federal government make available to states specifically what types of data will be used (time sensitivity of data) and how long it will take to make determinations based on data via federal systems. It is important that a consumer's experience in the exchange is seamless and expeditious as possible.
- A number of different metrics will be necessary for a consumer to effectively compare and contrast offered plans in the exchange. West Virginia will continue to research what metrics consumers feel are important. That being stated, there are a number of metrics that WV feels must be included as part of the information available to the consumer in the exchange. Per the NAIC, "Costs, taking into account premium tax credits;
    - Plan benefits;
    - Exclusions;
    - Cost-sharing provisions, taking into account cost-sharing credits;
    - Providers participating in the plan's network;
    - Cost and quality ratings;
    - Coverage facts labels.
- All information provided should utilize the uniform definitions of insurance and medical terms that are being developed pursuant to Section 2715 of the Public Health Service Act, as amended by PPACA. All enrollments should take place using the uniform enrollment form developed pursuant to the same section. If consumers need assistance, they should be able to receive help enrolling in a plan in a variety of non-electronic means, including in-person assistance from a trained individual that can provide approved information about the Exchange and assist consumers in completing enrollment forms. Each state will take a different approach to providing assistance at enrollment venues." These individuals should be properly certified and trained.

2. What kinds of information are likely to be most useful to consumers as they determine whether to enroll in an Exchange and which plans to select (within or outside of an Exchange)? What are some best practices in conveying information to consumers relating to health insurance, plan comparisons, and eligibility for premium tax credits, or eligibility for other public health insurance programs (e.g., Medicaid)? What types of efforts could be taken to reach individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

- See West Virginia's response to previous question.

3. What are best practices in implementing consumer protections standards?

- Per the NAIC, "State Departments of Insurance have extensive experience in providing consumer protections to health insurance consumers, and will continue to ensure that consumers are protected when purchasing coverage through Exchanges. State insurance regulators provide multiple levels of consumer protection, beginning when they review policy forms to ensure that they meet all state legal and regulatory requirements and provide all benefits required by law. Insurers' finances are reviewed on an annual and quarterly basis to ensure that they will have sufficient funds to pay claims. Agents marketing and selling insurance policies must be properly trained and licensed, and in most states, must maintain a contractual relationship with the insurer whose policies they sell that allows regulators to hold insurers accountable for the conduct of their sales force. Finally, insurers undergo regular financial and market conduct examinations, and when called for, are subject to targeted examinations to investigate problems that have been discovered through consumer complaints and other sources.

It will also be important to ensure continued multi-state cooperation among regulators to protect consumers. For over 135 years, state insurance regulators have coordinating regulatory efforts through the National Association of Insurance Commissioners ensure that regulator action is coordinated between the states and that all states are aware of problems as they emerge. Complaint data on insurers and producers are shared by the states and the NAIC serves as a venue for states to undertake multi-state market conduct exams."

K. Employer Participation

1. What Exchange design features are likely to be most important for employer participation, including the participation of large employers in the future? What are some relevant best practices?

- Efforts to engage the business community are underway. This issue is vitally important and will continue to be researched by the OIC in conjunction with appropriate state stakeholders. Anecdotally, cost and ease of use are two factors likely to drive employers' decision making with regard to exchanges.
- West Virginia would like to explore the idea of employers making limited defined contributions to their employee's coverage that could then be aggregated with

federal subsidies in the individual market. This would likely translate into more citizens having health insurance, a healthier exchange pool, and would allow employees to continue leveraging employer contribution to their health coverage in the job market. This would also give an alternative to employers that are not financially capable of providing for a larger percentage of an employee's coverage. Such a concept could be aggregated with the federal subsidy through a premium aggregator function developed as part of the exchange with an employer input code being established and linked with an employer account. A potential negative impact of this suggestion would be crowd out of the market. However, this could potentially happen for small employers regardless, especially after the tax credit for employers sunsets in 2016. Further guidance concerning this idea is requested.

2. What factors are important for consideration in determining the employer size limit (e.g., 50 versus 100) for participation in a given State's Exchange?

- The state will study this issue specifically as part of West Virginia's Planning Exchange Grant objectives. A mechanism must be found to prevent large groups with employees with poor experience disproportionately coming into the exchange over large groups with healthy employee groups so as to prevent adverse selection and the poisoning of the exchange pool.
- It is highly recommended that the Department of Labor and HHS work closely with one another, the states, and the NAIC to better define what groups are permitted to self insure and what groups are not and better determine the role of the self insured given the new parameters of the ACA.
- How does the federal government intend on engaging employers in federally operated exchanges?
- Do federal projections anticipate crowd out in 2016 when federal tax credits sunset for employers offering to cover 50% of employee coverage?

L. Risk Adjustment, Reinsurance, and Risk Corridors

- West Virginia is working closely with the NAIC in developing recommendations for these three components of the exchange.
- Is it anticipated that an all payer claims database will be needed in order for states to develop the risk adjustment tool? Will the federal government be developing an all payer claims database?
- Is it anticipate that HHS will ask consumers questions about their health in order to determine experience of consumers in various plans so as to develop a risk adjustment tool in states where the federal government operate the exchange?

M. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

- These issues will be further explored as part of West Virginia's research through the Planning Exchange Grant and SHAP.

N. Other Comments

- In federally developed exchanges, how will HHS differentiate between the eligibility of ACA eligible Medicaid recipients and pre ACA eligible Medicaid recipients?
- How will eligibility be determined for consumers that currently do not file income taxes?
- West Virginia believes that exchanges should always include an option for participating individuals and businesses to contact a certified, state-licensed agent/broker for assistance with their exchange-based coverage. Developing a mechanism by which to best facilitate this relationship and service is important so as to not preclude consumers from working with producers if that is the consumers' choice.
- Is it envisioned that a unique identifier will be necessary as part of the new coverage models? Will HHS be looking to develop a unique identifier for consumers at the federal level? Will funding be available to states to develop such a mechanism? It is recommended that ONC been engaged concerning the health information exchange's need for a unique identifier and the potential for using the same identifier for consumers in the exchange if deemed necessary.
- How often will financial data be updated for purposes of eligibility and subsidy determination? Is the exchange liable for erroneous eligibility determinations?
- West Virginia requests that HHS work with the NAIC and other national organizations in order to develop a strategy on how to deal with populations that cross state lines for care, coverage, work, etc.
- If health insurance coverage for public plans is carved away from traditional social services/ welfare eligibility systems then it is recommended that some type of referral system back to potentially available social services be created. States and relevant welfare agencies at the federal level should be engaged in this planning.
- There are a number of concerns being raised by stakeholder groups concerning the mandate. While this is clearly stipulated in the ACA, West Virginia recommends that HHS study the mandate penalties closely with States for efficacy, effectiveness, and other issues that may either make the mandate an ineffective tool in compelling consumers to purchase coverage or a financially burdensome penalty for populations that already struggle with financial stability.